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CLINICAL DIAGNOSIS IN MENINGITIS.*

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The clinical diagnosis of the meningitides is attended with some difficulty, and, in fact, owing to the similarity of the clinical symptoms of the different varieties, is well-nigh impossible. The purpose of this paper is to bring out to the fullest extent possible helpful discussion, as a means of enriching our meagre knowledge of this important infantile disease. The varieties of meningitides I will speak of are tubercular meningitis, cerebro-spinal meningitis and simple, serous or purulent meningitis.

The anatomy of the meninges in the child and adult do not differ materially. In all cases of meningitis we have symptoms due to pressure, infiltration or circulatory disturbances of the meninges and cerebellum. These conditions causing numerous manifestations of irritation, paralysis, hyperæsthesia and disturbances of the circulatory and respiratory centers; giving the various clinical pictures which we will discuss. The first symptom, that of headache, is constant and is unnecessary of comment, although it will have to be taken for granted in the very young. The disturbances of the sensorium or so-called phsyic changes are likewise always present to a varying degree, but bear in mind that continuous careful clinical observation find them always present in the following sequence. In the beginning moodiness, disinclination to play, peevishness, drowsiness, apathy, leading to delirium and coma. The physical changes run a most varied and, as I wish to emphasize, a most enigmatical course, being found frequently in other diseases other than meningitis—*i. e.*, acute articular rheumatism, enteric fever, influenza and pneumonia.

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Fever is present in a varying degree of a most irregular eccentric type and must be carefully observed, although I wish to emphasize the fact that in two cases that have come under my observation the fever was absent for limited periods and in several cases was very slight, the temperature never reaching more than 100° in any period of the disease. Intercranial or spinal pressure caused by increased inflammation develops varying symptoms. These are vomiting, which, I believe, is always centric in origin; brachycardia in the beginning, due to irritation of the pneumogastric nerve, and towards the end tachycardia. Hypertony of the muscles is another constant symptom, especially of the cervical muscles, when the inflammation is localized in the occiput. Kernig's phenomenon can always be detected in the milder cases—"inability to extend the leg when patient sits upright, owing to tonic spasm of the flexor muscles; but is of no value as a symptom when patient is prone. Cervical and spinal rigidity is a valuable symptom when rheumatism, spondylitis and hysteria can be excluded. Intercranial pressure, when directly demonstrable and not deduced, is an invaluable aid in the diagnosis of meningitis. This is, of course, only possible in infants with sufficiently large anterior fontanelles, where the increasing bulging and tension is the most reliable sign of meningitis in early life. It should be remembered that bulging of the fontanelles is indicative of meningitis only if child is quiet, and if other causes, pneumonia, diarrhoea, etc., can be excluded. I wish to emphasize to you, as perhaps the most important point in this paper, that cases of meningitis may run an almost symptomless course or be obscured by other diseases, and that we are indebted to Dr. Quincke for introducing lumbar puncture as an invaluable aid to our diagnostic methods.

Tubercular Meningitis.

Clinically tubercular meningitis may give the impression of being an independent disease, but the fact remains that it is *always* secondary to tubercular infection existing elsewhere. The history of tuberculosis existing in the family is of great importance. Examination of the glands, of the lungs, of the urogenital apparatus, of the osseous system, of the ears for otitis media, should be a routine practice. The primary foci in children are usually in the lymph nodes. Of these the submaxillary and cervical, which receive the lymph from the nose and pharynx, or the mediastinal or bronchial

glands, are the most frequent source of infection. A history of infectious fevers, especially measles or whooping cough, may act as seems to have no influence, and the only influence that age has is that the great majority of tubercular meningitis cases develop from the second to the sixth year. There is a longer period of prodromes in tubercular meningitis than in either cerebro-spinal meningitis or an exciting cause by stimulating a dormant tubercular focus. Sex in the purulent form. From one to three weeks the child may be restless, have a little temperature, be peevish, cry constantly, lose its appetite, be constipated, and upon examination at this time no symptoms will be elicited. The symptoms persist—patient groans in his sleep, gives the cri-encephalic, has headache, the fever continuing of an intermittent type; commences to become drowsy, sits still and quiet for a long time, gradually growing weaker; then is put to bed, and upon examination we may find the fontanelle of young children bulging. A commencement of rigidity in the cervical muscles is present, but not as great as in the cerebro-spinal variety. There is more coma and stupor than in the cerebro-spinal form. The tendon reflexes are exaggerated, brachycardia, pulse being 60 to 70 per minute,—there is more often tachycardia in cerebro-spinal meningitis,—the pulse is irregular, but not to the eccentric extent that it is in cerebro-spinal meningitis; the pupils are unevenly contracted in tubercular meningitis and the choroid upon ophthalmoscope examination may show tubercles. The coma and mental symptoms exist in all varieties of meningitis, but are greater in the tubercular meningitis and the purulent meningitis than in the cerebro-spinal meningitis, and in the tubercular meningitis are much slower in their development. An important point in tubercular meningitis is that upon the development of “unconsciousness absolute” the cervical rigidity and tonic spasm of the muscles disappear, and the temperature and the pulse increase gradually; and while very irregular, usually have an afternoon exacerbation, which is not the case in either of the other two forms of meningitis, as tachycardia and eccentric irregularity of the temperature is the rule of both. Tubercular meningitis begins very rarely with tonic spasms and convulsions, which is not the case in cerebro-spinal meningitis.

Cerebro-Spinal Meningitis.

The prodromal period is short, if it exists at all, the disease beginning usually with a chill, fever, convulsions and projectal vom-

iting. Very eccentric fever, having no definite time for exacerbation, pulse fast, very irregular and influenced by the slightest irritation, as walking across the floor or moving patient. The second day development of pronounced cervical spasm and herpes labialis, and herpes nasialis and petechial spots. These are never found in purulent or tubercular meningitis. And, too, cerebro-spinal meningitis is epidemic, is never isolated; the history of other cases of course aids in the diagnosis. There is a greater degree of pain in cerebro-spinal meningitis than in the other two forms, the pain being particularly dorsal. Rarely total unconsciousness except just before death, the mind remaining clear; and, in fact, the brain being unusually active. Special senses being very acute, the slightest noise or jar sending patient into clonic spasm at once. Differing again from the other forms of meningitis. Many cases having little fever and no cervical spasm, owing to the vomiting, may be mistaken for a simple gastritis. The pupils react evenly to light and upon touching the body, which is usually extremely hyperæsthetic, the pupils will immediately dilate. This dilatation of the pupils has also been observed as more or less constantly following the respiratory act. At the pause that exists between inspiration and expiration, the pupils will commence to dilate in the beginning of inspiration, and will frequently keep time with it. I do not know the cause for this symptom, but have observed it, and it is mentioned by Leube and Schlossman. Emesis is constant and recurs at intervals in cerebro-spinal meningitis; is rarely present except in the beginning of tubercular and purulent meningitis. Facial paralysis may occur in the tubercular or purulent form of meningitis, but never in the cerebro-spinal variety, which, in fact, may have a paraplegia of spinal origin.

Simple Serous or Purulent Meningitis.

Begins suddenly with high fever and extensive corticle symptoms. In tubercular meningitis there is a prodromal period and is slow and insidious in its beginning, while the cerebro-spinal variety begins with a chill, convulsions and vomiting. The purulent or serous form may be found in the new born; never find the tubercular meningitis under four months. The purulent form usually follows or accompanies infectious diseases or pyemia of some form, which is not true of the two former diseases. In portraying the picture of diffuse purulent meningitis it should be remembered that its aspect

is modified by a consideration of whether the disease attacks a previously healthy child or one that is seriously ill—with, for example, pneumonia. In the latter case it is not unusual to have the symptoms of meningitis obscured by the pre-existing disease, and to have the meningeal symptoms escape detection because the prostration of the primary disease overshadows the cerebro-spinal symptoms. The disease commences suddenly with a greater degree of temperature and tachycardia than in either of the preceding diseases. Delirium is almost always immediately developed, of a wild maniacal character. Distressing pains in the head evidenced by wild cries when head is touched; cervical rigidity is rarer than in the tubercular or cerebro-spinal form, but epileptiform and clonic-tonic convulsions occur with great frequency in single limbs or groups of muscles. The hands and fingers seem to be the favorite site of irritation. Short, small and not very tense spasms occur at intervals of two to three minutes. Trismus occurs with frequency in this form of meningitis, but is rare in the other types. Irregularity of the pupils, while occasionally present, is not as constant as in the tubercular meningitis. What is far more common is the development of oculomotor changes as a result of corticle irritation, spastic, strabismus, nystagmus, temporary conjugate deviation or sometimes paralysis. From what has preceded we can see the difficulty at arriving at a correct solution. In conclusion, I would say that tubercular meningitis is properly a cerebral disease with basilar manifestations; that cerebro-spinal meningitis is a spinal meningeal disease with cerebro manifestations; that the simple serous purulent meningitis is a cerebral disease absolutely.*

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CLINICAL LECTURE NOTES.

Dr. Dowling stated that while he could not hope to present any unusually interesting cases, he had thought that if he could get together a group of the more common cardiac lesions illustrating the more common murmurs it might serve the purpose of refreshing the memories of some of the gentlemen present whose recollection of the fine points of cardiac diagnosis might be a little hazy.

*Credit acknowledged to Dr. Schlossman for many valuable suggestions.

He would try to give an opportunity to every one who wished to do so to listen for themselves and would have a word or two to say on each case about the points of the particular murmurs exhibited.

"Anybody can diagnose a murmur, that is a very simple matter, but the point in diagnosing heart lesions is to understand and realize just what the mechanical condition is, because it modifies to so great extent the whole line of treatment and in the prognosis determines to large extent what a man may or may not do and gives a clear idea how to handle the case. To say a man has heart disease and is a cripple is, in some cases, a crime, because it frequently happens that in cases of heart lesions the patient can do ordinary work without any trouble whatever. On the other hand, there are cases of cardiac lesion when for the patient to do anything is to run grave risk of shortening his life or of sudden death.

CASE I. There seems to be no history of any special interest in this case. The patient does not speak English. It has been diagnosed as mitral regurgitation. Of course, as you know, the first thing to do is to outline the heart. We must first find out where the heart is and thus determine whether it is enlarged, and if so which side is enlarged. Not infrequently the omission to take this precaution causes mistakes.

One thing to remember in diagnosing all murmurs is the "tripod of diagnosis"—first, the time of the murmur, whether presystolic, systolic or diastolic; second, the place where it is best heard, and, third, the direction of transmission of the sound. These three points are absolutely necessary to be noted in making correct diagnosis of cardiac lesions.

Now in this first case the sound is best heard at the apex. The time is systolic, which is proved by putting your finger on the pulse and noting the relation of the murmur to the pulse; and, thirdly, the sound is transmitted around to his left side. These three facts, easily discernible in this case, prove it to be mitral regurgitation, for no other heart lesion presents those three characteristics.

I want again to emphasize the importance of careful distinction between the diagnostic points of the different murmurs, because people fancy, sometimes, that if a man has heart disease he is a cripple. A big strong negro came to the dispensary not long ago with a sore on his toe. I examined him and found a very marked

lesion of the aortic valve. I asked him what his business was and found he was engaged in carrying bags of sugar on board steamers all day long, bags weighing about two hundred pounds each, and he had a very aggravated form of valvular disease. Then, again, a man with mitral insufficiency will do pretty good work so long as compensation is fairly well maintained. Of course in valvular leakage at the mitral his lungs fill up with blood and the strain comes upon the right heart. Now, so long as the right heart is able to take care of that extra strain and push the blood through the lung fair compensation is maintained. But just as soon as it gets to be too much for the right heart it dilates and leakage occurs at the tricuspid. That is nature's safety valve. If it were not for that something would have to break in the lung. But, instead, the blood gets back safely into the veins and in doing so gives you the tricuspid regurgitative murmur, which is rarely organic. It is nearly always functional.

Tricuspid regurgitation is heard best not at the apex, but at the angle of the fourth rib on the left edge of the sternum. It is always systolic in time and not conveyed to the left. It is more localized. You can also hear it, with the mitral, at the apex, and the question might be asked, why is it not all the same murmur. The differential diagnostic point is this. You get mitral regurgitation at the apex and when you move out toward the axillary line it first falls away somewhat and midway from the apex to the axillary line it approaches the maximum again, and if you work back again toward the apex it gets fainter and then louder. Now here is a diagnostic point I want to call special attention to: if you have got two murmurs compensation is breaking down. If you have only one, things are in pretty good shape. This patient has both sounds.

That tricuspid murmur is a thing to be watched for in croupous pneumonia. When the heart begins to fail the first indication is an increase of the area to the right, showing dilatation of the right heart. You should learn in croupous pneumonia to listen from the very outset down there at the fourth costal cartilage for that little wave of tricuspid regurgitation. It is a bad sign. It means that compensation is failing rapidly and it should always be looked after.

The next thing that happens when compensation begins to fail is that the systemic circulation begins to be overloaded and the first place where that is usually manifested is in the foot. There is no

special reason why that should be except the force of gravity. Some cases begin to show first in the liver. You will recall the sound of a dilated liver. At the mammary line the normal liver sound is at the lower border of the sixth rib and it follows the border of the ribs on the right. On going over this man carefully I find his liver is very much larger than it should be. This is passive hyperemia of the liver due to failure of the heart to push the blood along and keep it moving. [Turns patient with back to audience and tells him to take a deep breath.] You notice that the left side does not respond as well as the right. There is good resonance all down the right side and almost flatness on the left side; that is between flatness and dullness. In dullness there is some resonance; in flatness there is none at all. Flatness is only occasioned by fluid or something else in the pleura. In this case there is nothing in the pleura. Any amount of dullness may be occasioned by consolidation of the lung, but there is always a certain amount of air in the lung owing to the open bronchial tubes and you never get absolute flatness. This man has a marked degree of dullness on the left side, which is the side on which he habitually lies at night. Now this condition of the lung is practically the same as that which exists in the liver—that is, a passive hyperemia or stasis of the blood in the lung producing bilateral edema. In this case, however, there is not so much on one side as the other because he lies in bed most of the time and habitually on the left side.

It is only recently that these conditions of the lung and liver developed. A few weeks ago he had nothing but the heart lesion. He is gradually filling now. You can do a great deal with a heart and save a breakdown, and the lungs may clear up if compensation is re-established. Sometimes the dropsy will disappear, and if they go quietly and carefully along they will last a good while. But the least little irregularity will cause the heart to beat too fast and the dropsy will reappear. Sometimes they will get over three or four such attacks.

In reply to the question, How could you determine that the enlarged liver was due to passive hyperemia and not to something else, as carcinoma or syphilis? Dr. Dowling replied: "The enlargement of passive hyperemia is smooth and tense, while carcinoma would be nodular. The amyloid liver would be smooth and hard, but you would never get that without a history of syphilis or tuber-

culosis, and, furthermore, this coming on so rapidly is conclusive proof that it is passive hyperemia."

Speaking of tuberculosis, it has often been noticed that people with heart disease are not liable to tuberculosis. On the other hand, you should remember that modern pathology proves conclusively that about ninety-eight per cent. of everybody have tuberculosis some time or other, which goes to prove that consumption is not the "Great White Plague," as it is called, and is not, in reality, a very fatal disease. It is readily cured and its death rate is not nearly so high as that of measles. That is something to remember when diagnosing a case. With half-way decent care they will get well. It is true they may be badly crippled, but they have a fair working chance to get well.

CASE II. This man has a double mitral lesion and a single aortic lesion. He has two murmurs and a presystolic thrill. This latter is the vibration of the mitral valve as the auricle forces the blood through its contracted orifice. It always comes before the ventricular systole and can be plainly felt in this case. Of the two murmurs the first is systolic, a mitral regurgitant murmur, which is important to note when you are considering heart murmurs, because if you have a regurgitant murmur the prospects for your patient are very much worse. The second murmur is that of aortic stenosis. It is also systolic and is continued upward and accompanied by the second sound in the carotid. The second sound in the carotid is due to closure of the aortic valve. If there is aortic regurgitation you hear the first carotid sound but not the second. But in this case you get the murmur and the second sound. Aortic murmurs can be disregarded if the mitral valve is all right.

Replying to a question concerning treatment, Dr. Dowling said: Where the heart is breaking down and lesions are beginning to show the best drug I know of is digitalis. I do not mean the potency. There is one very important point about the use of digitalis for failing hearts: the infusion is the form in which to use it. The tincture does not do at all. And unless you can get the infusion freshly made you might as well not give it. It should not be used more than two or three weeks old and should be given in teaspoonful doses. You should make your own infusion once or twice a week from fresh leaves if possible.

CASE III. It is pretty hard to diagnose myocarditis except on

general principles. This man's heart is dilated. Of course he has a great deal of edema. The case is five years old. He has been drinking a little beer for fifty odd years. It is safe to assume that he has hardness of the coronary arteries. This implies faulty nutrition of the heart muscle and the consequence is myocarditis, of course.

CASE IV. This is a case which I have never seen before. The history shows that he came to the hospital four days ago. Two or three weeks ago he had the grippe, which got better, and he got out before he should have done so. He took a few drinks of brandy and then went on a spree. Had an abscess of the ear about four years ago which discharged pus for six months and, suddenly stopped, and he has been dizzy and stupid more or less ever since. Further than this there is nothing significant in his history. My only idea in bringing him in was to take his blood pressure and see if this vertigo of which he complains might be due to arteriosclerosis. This is a condition which is too often overlooked until it gets so bad that you can see it. The early symptoms are a little vertigo or, more accurately, a swaying and a tendency to occipital headache. When you meet with these symptoms the best thing to do is to look for the causes which produce them. You cannot cure arteriosclerosis, but you can prevent its rapid onset and postpone the result. I find upon examination that his radials are quite fibrous, which may be due to lead poisoning—he is a sign painter, I understand—but he says he has never had lead colic.

The patient's blood tension was then taken by the sphygmomanometer and found to be 168.

Dr. Dowling continued: "High blood pressure is one of the positive physical signs of arteriosclerosis. This man's pressure is 168. The normal is 120. We have therefore indications of arteriosclerosis from high blood pressure. This should be confirmed by urinalysis. Just here let me say that it is a great error to take a single specimen for a diagnosis; a twenty-four hour specimen is absolutely necessary. With such a blood pressure this man would be almost sure to show some renal complication. The only thing of significance in the urinalysis is the total solids. You want to know what is doing in the way of elimination. It does not matter whether there is a little albumin; it does not make a particle of difference.

The old cardinal signs of heart disease used to be hypertrophy

of the left ventricle, extension of the sound and hardening of the arteries. He has got hypertrophy of the left ventricle because the apex is to the left of where it ought to be. He has hard arteries and extension of the sound. The case is one of arteriosclerosis beginning to affect the cerebral arteries. If he were a man in business and not using his arms and legs he would have more trouble than he is now having.

Drinking coffee, alcoholism, too great pressure in business, too great brain work, anything that unduly exercises or excites a man tends to arteriosclerosis. The effect is to keep the arteries stretched and consequently to destroy the intima, and this resulting in sclerosis cuts off nourishment from the brain and brings on early incapacity for all mental activity with apoplexy and that class of troubles. A man might as well be dead as be unable to use his brains.

TUBERCULIN TREATMENT.

By E. Guernsey Rankin, A. M., M. D.

I will endeavor this afternoon to show you something of the method and effects of tuberculin. With this in view I have here several cases from the Metropolitan Hospital who have been under this treatment.

You will recall that about the year 1890 Dr. Koch discovered in the culture of the tubercle bacillus a substance which he found was productive of reaction in a tuberculous patient. Subsequently an observer by the name of Bujwid made experiments along the same line and was quoted by Reesen as having confirmed the discovery of Koch. He gave the new substance the name of tuberculin, a name which Koch himself subsequently adopted.

You will recall also that the advent of tuberculin was greeted by the medical world with great enthusiasm, and that all seemed to think that the long-looked-for specific for tuberculosis had been found. It was very extensively tried and, as you know, was found wanting. It was not only *not* a specific, but its administration was attended with disastrous results and it was soon abandoned.

Since then there has been a revival of interests in tuberculin, and in the last few years it has been quite extensively employed by different observers,—in part as an actual therapeutic measure, and in part as an experimental expedient.

You will recollect, again, that the first tuberculin is called "old tuberculin," and was prepared by Koch from the elements of the tubercle bacillus after five to six weeks' culture in five per cent. glycerine bouillon. This substance was reduced to one-tenth of its volume by evaporation and then filtered through porcelain, so that all the germs were removed; there was then added six per cent. glycerine. Denys' filtrate is prepared on the same lines, except that heat is not employed.

Then there is "new tuberculin," which Koch prepared from virulent cultures, evaporating the same *in vacuo*, and then triturating or grinding the germs in agate mortars. He regards this tuberculin as especially antagonistic to the germ itself, while the old tuberculin is regarded by him as antagonistic to the toxins of the germ.

There is still another preparation, the bacillus emulsion, prepared from the virulent germs—one part added to fifty of water and fifty of glycerine. There is also the Spengler-Perlsucht preparation, made from the "pearl disease" of cattle.

Last autumn Professor Denys, of the University of Louvain, read a paper before the International Tuberculosis Congress and subsequently before the New York County Homœopathic Medical Society on the use of the tuberculin called by his name. His report of it was so encouraging that I was inspired to attempt, in a small way, experimentation along the same line. (Let me say, in passing, that tuberculin filtrate was not originated by Prof. Denys, although he has brought it more prominently before the profession. It was first suggested by Spengler.) I accordingly selected at the Metropolitan Hospital twenty-two cases of pulmonary tuberculosis, —with few exceptions more or less advanced, and placed them under treatment. Of this number, two have died and two left the hospital, leaving eighteen. Of these eighteen, I took six off the treatment, leaving twelve, which have been under treatment from the middle of November until the present time.

The doses of tuberculin, of the several varieties, as prepared by Mulford & Co., of New York and Philadelphia, is as follows: There are five dilutions, numbered from one to five. The first dilution is the initial series; of this, two minims contain $1/1000$ of a milligram of tuberculin. The second dilution contains $1/100$ of a milligram in two minims; the third, $1/10$ of a milligram in two minims; the

fourth, one milligram; and the fifth, ten milligrams. The doses are given hypodermically,—beginning, as I have just stated, with two minims of the first dilution. The next dose is four minims of the first dilution; the next, six minims; the next, eight; and so on, increasing by two minims until twenty minims are given of the first dilution. Then that series is exhausted, and we begin on the second dilution and give the same series of doses until twenty minims is reached; then the third, fourth and fifth dilutions are given, and the course is completed.

As regards the frequency of the dose, the working bulletins which are published by the different chemists, giving instructions, are of great value, but one's own experience must be the guide to a certain extent. It is stated that the dosage in the beginning may be administered every three or four days, and at longer intervals as the strength of the dilution progresses. It is not specified exactly how long the intervals should be, but you are to be guided by the amount of reaction. By reaction is meant the febrile course, the elevation of the temperature,—little or great,—any symptom of general disturbance, increase of expectoration, headache or hoarseness, loss of appetite or strength, or tendency to hemorrhage; and, locally, any inflammatory reaction around the point of puncture.

The general indications for the use of the remedy are as follows: an afebrile condition, or at least a temperature of not above 99.5° , and freedom from tendency to hemorrhage. By this I do not mean that a case which has once suffered from hemorrhage should not be subjected to tuberculin, but if there is bloody expectoration the tuberculin should by no means be given as long as it continues. Cases which are subacute in their conditions or which are chronic are particularly well suited for the remedy, especially a case which has existed for some time and remains quiescent. Of course you must have something to work on, however; you cannot take a far advanced case and expect satisfactory results. The presence of tuberculosis of the kidney and the hemorrhagic cough and much emaciation are contraindications.

As stated, of my twenty-two cases I throw out two who left the hospital, and eight withdrawn from treatment; two of the latter have since died. These two at first showed improvement. Whether it was the suggestion that something new was being done for them, or whether it was real, it is difficult to say. They were well ad-

vanced cases, too far advanced, in fact, and should have been taken off the treatment earlier. Their temperatures were elevated, they became weaker and their cough increased. When taken off the treatment they continued to decline. The question would naturally arise: whether the treatment hastened their end. I must confess I am afraid that it did. The other six men who were removed from the treatment began in very much the same way, but I did not wait so long and took them off quickly. They have not improved, nor have they gone back very much.

I do not think it would interest you to go over these cases in detail, as far as the physical signs are concerned, but I will ask your attention to the temperature, charts and the history.

Case I. This man has been ill of tuberculosis for four years, and has been in the Infirmary since July, 1905. He is of the chronic type. There has evidently been an effort on the part of nature to bring about a condition of fibrosis. He has had considerable power of resistance; at the same time his lungs are both extensively involved. He has remained about the same for a number of years. At his own solicitation we gave him this treatment. Before treatment his temperature ranged from 98° to 98.5° , and twice only went to 99 and a fraction. The chart during treatment shows a decided break in the curve, the result of reaction. Now we are told that when there is a reaction one must wait until that has entirely subsided before continuing the treatment. It is also sometimes advisable to repeat the same dose before passing to the increased dose. I notice that there is occasionally, what appears to be, a secondary reaction—that is, on the second or third dose there is sometimes an elevation of temperature. The chart shows no marked variations of the curve, and when we get to series No. 3,—twenty drops,—we find it more even.

I have observed that in almost every case treatment seems to stir up conditions and at first break the temperature curve.

As far as improvement is concerned, I do not depend alone upon the indications of the temperature curve,—although of course that is very important,—but on the general condition as well. All the time this man would say he felt better. He gained as much as seven pounds in weight, but then lost it. Since the first of his illness he has lost as much as twenty-five pounds. He claims that his cough has improved, especially in the mornings, although he still

expectorates some in the morning. In other words, there is a great diminution of expectoration and cough. He is now taking Series No. 5, which is the maximum dose of tuberculin. The microscopic examinations of the sputum vary: Last month the result was negative, this month it is positive; it is less frequently negative than it was. On consulting the record, I also find that the bronchial breathing, which was very extensive, is less pronounced, and that the resonance at the base of the lung is better; while the physical signs of involvement are still marked, there is generally less intensity of the symptoms.

Case II. This man is now taking Series No. 4. He is on the sixteen minim dose. His temperature chart first shows breaks, apparently reactions, the line being very much broken, yet all the time he declared he was feeling better; later you will observe that the line begins to become a bit more even, showing some degree of tolerance. You will observe, however, in all these cases a little irregularity in the temperature, with reactions now and then. This man has gained eleven pounds.

Case III. Six months ago the right apex showed slight consolidation, as indicated by prolongation of the respiratory murmur and dullness at the seventh rib, with some slight resonance in the left side. He has hypertrophy of the heart to a limited extent. He has gained eight pounds and has very little cough, and is decidedly better.

Case IV. This is a positive case. Some of the examinations have been negative, being last negative on the 9th of May, after three examinations. I consider this man a particularly favorable case.

Case V. This man has had a slight consolidation of the right apex. He is generally in pretty good condition. He was not emaciated and his temperature curve was afebrile. I hesitated to put him under treatment. He had been in the hospital from six to eight months, but he wanted to take the treatment, and I gave it to him. Possibly he might have been restored without treatment, but at any rate he seems now to be entirely well. There is a slight prolongation of the respiratory murmur and a slight roughness still at the apex. The cough is gone and the expectoration is negative.

Case VI. This man is a pronounced case, and in the course of treatment he had a marked hemorrhage,—not of the gushing va-

riety, as if an artery had broken, but of that type where there is a constant expectoration of blood is comparatively limited,—from half a dram to a dram at a time. He was put to bed and tuberculin treatment was suspended. He had had a hemorrhage six months previously. Whether the treatment had anything to do with the second hemorrhage I cannot say, but I do not think so. His temperature ran up after the tuberculin treatment was commenced, as high as 100° . Still we kept on. Perhaps we should not have done so. Then the curve began to become more even. All this time he certainly was improving. It seems as if, notwithstanding the reaction, he became more tolerant of the remedy, judging from the temperature level. During the hemorrhage the temperature went up to 102° , 103° and 104° . He lost eight pounds during this period and has gained nothing since. The hemorrhage took place in December. Since then he has held his own, and claims that the cough is a great deal better and that the expectoration is less.

Case VII. This patient has gained eleven pounds. His cough has almost entirely disappeared. He still expectorates a little by hawking. Notwithstanding the favorable course of this case, on the 9th of May the sputum showed bacilli.

I do not see that any observers make note of elevation of temperature on the second, third or fourth day after the injections, but I have often observed it, especially in this case. He had one decided reaction later. In such an instance as that it is advisable to repeat the same dose.

I wish to emphasize what seems to me the most important point in this method of treatment,—that is, its dosage. This is the key to the whole situation. The reason why tuberculin failed so utterly at first was because it was used in too large doses. Now we are learning, but I must say we have not progressed farther than learning. We do not know it all by any means. Tuberculin is like a sharp-edged instrument; properly used, it is capable of great efficiency; improperly used, it is capable of infinite damage. The first point I wish to make is in regard to the smallness of the dose, at least in the beginning. The first dose is $1/1000$ of a milligram or, as I figure it, $1/666,000$ of a grain, approximately, equal to about 154 grains of a seventh decimal dilution of the homœopathic scale. Small as this dose is, some observers recommend still smaller ones.

One ten-thousandth of a milligram has been suggested, yet notwithstanding its smallness you will sometimes observe reactions. The next point in the administration of the remedy is the selection of the case.

The books will tell you to give the remedy three, four or five days apart, or once a week; but you must take each case by itself and see how often the patient needs it, and if reaction calls for a repetition of the series before increasing the dosage.

Case VIII. This case presents another type of tuberculosis. He has pleurisy with effusion and consolidation of the lung on the affected side, and has been in the hospital for eleven months. His sputum was positive. He lost twenty-five or thirty pounds before entering the hospital and has regained about three pounds since. He has been brought before you simply to emphasize what you already know—the relation of pleurisy to pulmonary tuberculosis. You will recall that the bacteria responsible for pleurisy are principally the bacillus tuberculosis, pneumococcus lanceolatus and the streptococcus. In the case of pleurisy with effusion the microscope naturally has an important bearing on the prognosis. If you find that the sputum is negative, it suggests tuberculosis, for it takes a large quantity of tuberculous pleuritic serum to give positive results. A small quantity injected into a guinea pig may be negative, while a larger quantity may be productive of results. It has been variously estimated that from thirty to sixty per cent. of all pleuritic effusions are tuberculous. Therefore when we have a case of pleurisy it behooves us to look out for tuberculous development. If, on the other hand, the serum indicates the presence of the pneumococcus only, you have a correspondingly more favorable prognosis. This man illustrates this very well. He has the so-called classical physical signs of pleurisy with effusion, and on inspection you will find bulging of the affected side with loss of motion. On percussion there is the flatness found in pleurisy with effusion, and there is a total absence of fremitus, which is of course a positive sign in association with the flatness. Then, on auscultation, you will find very feeble respiratory murmurs. This patient, although his pleurisy is of some standing, has come under my observation only within the last few days, and I recommend that the chest be aspirated and that he then be put on some particular line of homœopathic constitutional treatment. While experimenting on other

lines at the Metropolitan Hospital, we by no means forget the homœopathic remedies.

I do not, as I said in the beginning, presume from this limited number of cases that I have arrived at any positive conclusions in regard to the administration of tuberculin. All I can say is that I have obtained some valuable suggestions from actual experience, and I propose to continue on these same lines. Not necessarily with Denys' tuberculin, but perhaps with some other.

There is another method of experimental treatment to which I want to call your attention, and that is the use of succinimide of mercury. A series of observations with the remedy carried on at the United States Hospital at Las Animas, Colorado, on some two hundred cases showed favorable results.

Our last case is one in which we have used this method, and I have brought him here to illustrate the method to any one here who may not be familiar with it. This is a case of pulmonary tuberculosis. He came to the hospital about two weeks ago. His cough is severe. He has gained three pounds during the treatment. Of course, we cannot expect anything very marked in so brief a period. The dose of the succinimide of mercury is a fifth of a grain hypodermically every other day for thirty days; then for two weeks iodide of potassium—five grains three times a day; then one week's rest, after which the course is resumed. That is the so-called new mercurial treatment of pulmonary tuberculosis. What its value will be it remains for the future to disclose.

ECHINACEA.

By Dr. J. C. Fahnestock.

It was Herbert Spencer who said that the first requisite for success in life was to be a good animal. Possibly no one ever recognized this fact so keenly as he did. For many years he was obliged to limit his work to two hours a day owing to his physical condition. But by having set methods and principles he accomplished great ends.

No able-bodied man is ever handicapped except by his own faults and weaknesses. With strength, vitality, and honor, success is a mere matter of ambition and patience.

We must love our work, and that to a passion. If one has been fortunate enough to find the work for which he is best fitted—and

in the study of *Materia Medica* I have found mine—that work should be a constant stimulation and refreshment of spirit.

All study to be successful should be systematic. In the study of the *Materia Medica* there should be some fixed method in order that the many features seen in the wonderful workings of medicine can be easily grasped and retained. These features must be so plain that they become a permanent fixture in the student's workshop.

The immortal Hahnemann, who laid the foundation of our *Materia Medica* and who built much of its superstructure, has told us in a very plain way how we can become familiar with this, the greatest factor in our profession. Hahnemann recommends that every one prove medicines upon himself, so he can be thoroughly conversant with their actions. Listen to what he says:

"Those trials made by the physician upon himself have for him inestimable advantages. In the first place, the great truth that the medicinal virtue of all drugs, whereon depends their curative power, lies in the changes of health he himself has undergone from the medicine he has proved, and the morbid states he himself experienced from them, becomes for him an incontrovertible fact.

Again, by such noteworthy observations on himself he will be brought to understand his own sensations, his mode of thinking and his disposition, and he will also be trained to be, what every physician ought to be, a good observer. All our observations on others are not nearly so interesting as those made on ourselves. The observer of others must always dread lest the experimenter did not feel exactly what he said, or lest he did not describe his sensations with the most appropriate expressions. He must always remain in doubt whether he has not been deceived, at least to some extent.

These obstacles to the knowledge of the truth, which can never be thoroughly surmounted in our investigations of the artificial morbid symptoms that occur in others from the ingestion of medicines, cease entirely when we make the trial on ourselves. He who makes these trials on himself knows for certain what he has felt, and each trial is a new inducement for him to investigate the powers of other medicines.

He thus becomes more and more practiced in the art of observing, of such importance to the physician, by continuing to observe himself, the one on whom he can most rely and who will never deceive

him; and this he will do all the more zealously, as these experiments on himself promise to give him reliable knowledge of the true value and significance of the instruments of cure that are still to a great degree unknown to our art.

Let it not be imagined that such slight indispositions caused by taking medicines for the purpose of proving them can be in the main injurious to the health. Experience shows, on the contrary, that the organism of the prover becomes, by these frequent attacks on his health, all the more expert in repelling all external influences inimical to his frame, and all artificial and natural morbidic noxious agents, and becomes more hardened to resist everything of an injurious character, by means of these moderate experiments on his own person with medicines. His health becomes more unalterable; he becomes more robust, as all experience shows."

Von Boenninghausen, one of our greatest students of the *Materia Medica*, soon became thoroughly acquainted with Hahnemann's works, and it was he who gave us the great work on the relative value of symptoms produced in the provings of drugs.

Hull's *Jahr* tells us how to become acquainted with the *Materia Medica*. Hear him! Listen!

The complete knowledge of the *Materia Medica* is not as difficult as has been generally thought, and all depends upon the manner in which it is undertaken. By proceeding in a methodic manner, and by progressing from generals to particulars, the student cannot fail in the end to master the most complex lessons of this art. The course of study should begin with those medicines which are most useful, and gradually extend, step by step, down the scale of importance till the remainder are understood also.

The homœopathist, in making choice of a remedy for a case of disease, excludes none of the medicines from the inquest, but takes all under consideration impartially; and in the practice it is indispensable to take this course.

Whilst, in the preparatory study of the *Materia Medica*, it is better to avoid the attempt to consider all the medicines at once, and to study only a few of them at a time."

Most of the great students of the *Materia Medica* thus systematize their work. They learn to know what is the general state of affairs that runs through a given medicine, and those conditions that are particular. And, finally, they note these conditions that are

found in many medicines—those that are known as common conditions and common symptoms.

If we only start right and then keep moving, and have our determination freshened day by day, we will soon be surprised to know what an interesting study *Materia Medica* is. The cry “too voluminous,” “too many symptoms of no value,” not a scientific proving, will rarely be heard from the real student physician.

The propagandism of Homœopathy will begin by seeing more *Materia Medicas*, more repertories in use all the time. I venture to say that the majority of physicians do not give one hour a week of solid study to the *Materia Medica*, while many do not see a *Materia Medica* once a month. It is not surprising to see all kinds of junk decorating their offices and, on the other hand, nothing at all of real value to a student. They like to study remedies from journals, and Heaven save the mark when we get it from teachers of *Materia Medica* this way:

Echinacea.

Cankered sore mouth. Gums recede from teeth and bleed easily. Corners of mouth and lips crack open: tongue dry and swollen, covered with sordes. Phlegmonous inflammation of the tonsils; the more strangulated the circulation the better *Echinacea* is indicated. It has great action on the skin. Irritation from poisonous plants, stings and insect bites; recurring crops of boils. Infected wounds.

Another one tells the students “give *Echinacea* in teaspoonful doses in typhoid fever every two hours, for two days at least, to insure a perfect disinfection of the bowels.”

Hear this: “*Echinacea*, the great remedy for suppuration troubles; the more the pus the better it is indicated.” Wonderful! (?)

With these few preliminaries I will give a few of the conditions set up by *Echinacea*. It is quite likely that that which I will give will be somewhat disappointing, but it will be a general review of provings which I made upon myself some years ago. Provings made from tincture and the different potencies. Provings continued for over two years. By this I mean that a proving was made, then its full action was awaited before another trial was attempted.

There is a “tired feeling” that runs all through *Echinacea*. It is the great “tired feeling remedy.” Tiredness is one of the general symptoms that goes to make up the *Echinacea* cloth. Tiredness.

There is a general languor, a general depression, with weakness. That tired, weak feeling becomes greater as the day passes by, so that the person is indisposed to make any motion.

This indisposition not only affects him physically, but mentally. A general dullness with drowsiness; does not want to make mental or physical effort during the day-time. Later, during the night, and especially after midnight, he becomes restless and wakeful and has a frequent desire to urinate. The urine is increased in quantity and pale in color. Later on the urine becomes diminished in quantity and dark in color. A number of provers experienced a heat and burning while passing urine. One prover had involuntary urination, as he expressed it, "I had involuntary urination in spite of myself."

A general depression of body and mind. The person has a great indisposition, dullness and confusion in the head; becomes angry at mere trifles; very irritable, cannot bear to be crossed or corrected. The brain becomes dull and confused; much out of sorts in general. Complains of tiredness in his head, cannot think, wants to be let alone; if disturbed he becomes irritable and cross.

A tired feeling in every part of the body;—the head feels tired, the eyes feel tired; if used, they ache and become tired.

Becomes dreadfully tired in holding a book to read; his eyes are tired, his arms are tired; in fact, he is tired all over.

All troubles are worse in the afternoon; has a dull feeling in his brain, the brain feels too large. Dull, full feeling in forehead; dull pain in the occiput.

Head felt as big as a windmill, with mental depression. Echinacea slows down the function of digestion. The stomach seems to become tired and the mouth fills with sticky mucus; much eruction of tasteless gas. Belching of gas, which tastes of food that has been eaten.

The patient wakes tired in the morning with a bad taste in his mouth. Belches gas. Sour eruction. The sour eruction caused burning of the throat. Complete loss of appetite with nausea. After eating the stomach and abdomen filled up with gas. Constant belching of gas. Offensive gas passes the bowels. Diarrhœa which is very offensive, with much offensive gas.

The gas which fills the stomach and abdomen causes sharp, cutting pains. These pains come and go suddenly. Pain in the right iliac fossa.

I repeat again—that exhausted, tired feeling. Felt as if he had been sick for a long time. A general aching all over the body with exhaustion. There is an intense itching and burning of the skin of face and neck. Small red pimples on face which itch and burn. Conditions are worse after eating. Worse in the evenings. Worse from physical or mental labor. Better at rest.

THE TUBERCULOSIS CLINIC OF THE FLOWER HOSPITAL.

By Walter Sands Mills, A. B., M. D.

Professor of Medicine and Chief of Tuberculosis Clinic New York Homœopathic Medical College and Flower Hospital.

The special Tuberculosis Clinic at the Flower Hospital has been in operation since October 1, 1908. During the following winter it became a member of the Association of Tuberculosis Clinics and had a district assigned to it. A social service department was established and put in charge of a competent supervising nurse. The clinic has been going long enough now to get some idea of the work and its value. I will therefore give a brief summary of one hundred successive cases as they have presented themselves for examination.

Case 1. Non-tubercular. Transferred to the appropriate clinic.

Case 2. Man aged 44. Single. Formerly a bank clerk. Native of the United States. Two brothers died of tuberculosis. The patient has been sick five years, and under continuous treatment two years. The patient came to us March 1st, 1909. Physical examination showed both lungs badly affected, the right the worse. The sputa showed bacilli. From his general appearance and from his lung condition we thought he would live but a few weeks. He was given bryonia most of the time until October. For two or three months after that he had in addition an occasional treatment in Professor Dieffenbach's clinic with X-ray flashes. He claimed to feel better the day after each of these treatments for a time. Then he thought he was worse and refused to take them longer. He is still under treatment with bryonia. He has had an occasional hemorrhage, for which he has received aconite. He declined to go to a day camp on account of lack of car fare, and his pride would not allow him to accept financial aid even to that extent. He

spends his time on the streets, on the docks and in the parks, but always out of doors during the day-time.

The nurse reports the patient to live with two old people, one of whom works to support the household. They pay twelve dollars a month rent for four rooms, only one of which is light. The patient is intelligent and conscientious, and is trying to help himself by carrying out instructions.

Physical examination late in July, 1910, shows that the lungs are better. The patient looks better and, much to our surprise, really is better.

Case 3. Woman aged 37. Born in New York of Irish parents. Her husband died of tuberculosis two years ago. The patient presented herself March 22, 1909. Examination showed both lungs affected, the right the worse. Sputa showed bacilli.

The nurse reported the patient to live in a four-room flat, only one room light. The patient endeavored to carry out instructions.

Patient was sent to Liberty, New York, April 29. She returned in October, worse, and has since died.

Case 4. Woman aged 37 years, married, German. Maternal grandparents; both parents and seven brothers and sisters died of tuberculosis. Patient has been sick three years with a cough. Has had hemorrhages. Came to the clinic March 24, 1909, but was very irregular in her attendance thereafter. The patient was able to take good care of herself and did. Examined April 13, 1910, and showed nothing but a slightly increased expiratory murmur over the apices.

Case 5. March 31, 1909, a man 52 years of age, driver of a brewery wagon, presented himself for examination. There was no history of tuberculosis in his ancestry, but he was the father of fifteen children, eleven of whom were dead. Patient complained that he had had a cold all winter. Both lungs were affected, the right the worse. The sputa contained tubercle bacilli. The patient was transferred to a hospital, where he died in October.

Case 6. A man aged 44 years. He presented himself April 3, 1909. Both lungs were affected. He made a second visit May 15. He lived out of town and never made a third visit.

Case 7. A man aged 33 years. Presented himself for treatment April 10, 1909. The patient had served in the Spanish War and had been living on his record ever since. He was a drunkard,

brutal to his family, careless and disreputable in his habits. He had been in and out of several institutions. As he refused to do as he was told, his case was reported to the Department of Health, which forcibly committed him to one of their institutions. Both this man's lungs were affected.

Case 8. Man aged 67 years. Came to the clinic April 12, 1909. Both lungs were affected. He was sent to a hospital, as he was too sick to be about.

Case 9. Woman aged 43 years. Attended the clinic from April 17 till June, 1909. Patient gave a history of pneumonia and pleurisy three years before. Her husband had tuberculosis. Both lungs of the patient were affected. She was sent to a hospital in June, 1909, and died in April, 1910.

Case 10. Boy aged 7 years. Father dead of tuberculosis. Made only one visit, April 17, 1909. Slight catarrhal affection upper lobes.

Case 11. German maid servant, aged 29. Slight catarrhal condition of upper lobes. Attended the clinic April to June, 1909. Dismissed cured.

Case 12. Non-tubercular.

Case 13. Girl aged 16 years. Her father was a negro, her mother a Swede. Patient came to the clinic April 28, 1909. Both lungs were badly affected and patient was sent home and to bed. She died February, 1910.

Case 14. Woman, Russian Hebrew, aged 35 years. Patient had been sick for months with a cough. She made only one visit to the clinic, and that was in April, 1909.

Case 15. A Greek, man, aged 23. Patient attended the clinic during the month of April. In May he was admitted to the Sanitarium of the Department of Health at Otisville. In the summer he left Otisville and returned to Greece, where he has since died.

Case 16. Non-tubercular.

Case 17. Non-tubercular.

Case 18. Non-tubercular.

Case 19. Non-tubercular.

Case 20. Man aged 41. Both lungs affected. Patient made only one visit.

Case 21. Non-tubercular.

Case 22. German woman aged 55 years. She attended the clinic

from May 15 to August, 1909, against our advice, as both lungs were affected. She was finally prevailed on to go to a hospital, where she died. The patient was very poor, but clean.

Case 23. Man, Irish, aged 50 years. Made one visit, May 15, 1909, and then transferred.

Case 24. Non-tubercular.

Case 25. Non-tubercular.

Case 26. Woman aged 26 years. The left lung slightly affected. This patient was in my service at the Metropolitan Hospital for a time. Her lung condition was complicated by hysteria.

Case 27. Non-tubercular.

Case 28. Man aged 30. Appeared at the clinic April 17 and during May, 1909. Both lungs were affected and patient had a fistula. He was transferred to another district.

Case 29. Man aged 35 years. Both lungs affected. Patient made only one visit, May 10, 1909.

Case 30. Non-tubercular.

Case 31. Man aged 27 years. Came to the clinic May 26, 1909. There was no tubercular history in the family. Both lungs were affected, the right the worse. The sputa contained tubercle bacilli.

The nurse reported that the man and his wife lived in two dark rooms in a basement. There was a new baby in the family. Besides that there were two small children as boarders, for whom the patient and his wife received one dollar and a half a week.

The patient came only a few times. He died in March, 1910.

Case 32. Non-tubercular.

Case 33. Man aged 34 years. Both lungs were affected, the right the worse. The patient had served in the Spanish War, where he contracted malaria. Later he developed a cough, which eventually was found due to tuberculosis. The patient came to the clinic June 7, 1909. He was single and boarded. He was directed to attend the Day Camp on the Vanderbilt clinic roof. Later he went to the city's sanitarium at Otisville, where he still is.

Case 34. Non-tubercular.

Case 35. Non-tubercular.

Case 36. Italian boy aged 18 years. Both lungs affected. The patient came to the clinic twice in June, 1909, and was then sent to Otisville.

The nurse found the patient was one of ten living in three rooms. He died in December.

Case 37. Non-tubercular.

Case 38. A Jewess, aged 20 years. She came in June. The lungs were only slightly affected. She was transferred to her home clinic.

Case 39. A girl aged 15 years. The father died of tuberculosis. There was a slight lesion in the left lung. Her principal remedy has been iodide of arsenic, and she is doing well.

The nurse reported the family poor, but clean. All her days are spent at the Vanderbilt clinic day camp.

Case 40. Non-tubercular.

Case 41. Man aged 44 years. This patient had been in a tuberculosis hospital for seventeen months. The right lung was slightly affected. He made but one visit.

Case 42. Woman aged 35 years. Right lung only affected. She made two visits, June 28 and 30, 1909. She was transferred to her home clinic.

Case 43. Non-tubercular.

Case 44. Man aged 32 years, Hebrew. The right lung was the worse. He made two visits, July 17 and August 4, 1909, and was then transferred.

The nurse reported the living quarters to be very dirty.

Case 45. Woman aged 23. Russian Hebrew. Right lung the worse. She was sent to one of the day camps. She made but two visits to the clinic and then moved to another district.

Case 46. Woman aged 29 years. Russian Hebrew, wife of Case 44. Her lung involvement was slight. She made two visits and was transferred.

Case 47. Irish woman aged 50 years. Lung involvement slight. She was dirty and drunk. She appeared at the clinic July 21, 1909, and was examined and transferred.

Case 48. Woman aged 27 years. Both lungs involved, right the worse. She made one visit and was transferred.

Case 49. Woman aged 40 years. Her husband died of tuberculosis. She made but one visit.

The nurse reported good living conditions. Her sons worked and took care of her.

Case 50. Man aged 53 years. He was sent to Otisville after one visit at the clinic.

Case 51. Woman aged 24 years. Made but two visits. Lung lesion slight.

Case 52. Woman aged 35 years. Hebrew. Lung lesion slight. Made but one visit.

Case 53. Man aged 36 years. Made one visit and was then sent to Otisville.

Case 54. Man aged 30 years. Russian Hebrew. Left lung the worse. Was sent to Riverside Hospital for advanced cases.

Case 55. Boy aged 6 years. Made but one visit.

Case 56. Woman aged 39 years. One sister died of tuberculosis. Patient came to the clinic only during August, 1909.

Case 57. Man aged 21 years. Right lung only affected. Made but two visits, August 18 and September 1, 1909.

Case 58. Man aged 35 years. Left side the worse. Made but one visit, August 21, 1909.

Case 59. Non-tubercular.

Case 60. Non-tubercular.

Case 61. Boy aged 19 years. Russian Hebrew. Presented himself for examination August 28, 1909. He became my private patient in October. The apices of both lungs are slightly affected. He has a peculiar loose, explosive cough which hepar seems to help. Just at present, August, 1910, the patient is in Sullivan County, New York. He reports that his general condition is improving.

Case 62. Man aged 35 years. Both lungs affected, right side the worse. During September and October the patient spent his days at one of the day camps. At present he is at Otisville.

Case 63. Non-tubercular.

Case 64. Boy of 18 years. Father died of tuberculosis. Made one visit and was then transferred to his home clinic.

Case 65. Woman aged 38 years. Transferred to Bellevue clinic.

Case 66. Non-tubercular.

Case 67. Man aged 32 years. One brother died of tuberculosis. Both lungs affected. Sent to a hospital.

Case 68. Woman aged 18 years. Russian Hebrew. Comes to the clinic with an aunt, Case 75, also tubercular. This patient—Case 68—has been a regular attendant at the clinic since September 20, 1909. In November she was married. She has been steadily going down hill ever since. Her weight is diminishing and the disease is slowly but surely progressing in the lungs, both of which are now affected. She is in comfortable circumstances. In March

she was curretted for some uterine condition. She has had various remedies as they seemed indicated, but, nevertheless, is not doing well. Why, I do not know.

Case 69. Girl aged 12 years. Came to the clinic September 20, 1909, and still reports once a month. Slight lung involvement. The home conditions are good. Patient spends her days at one of the day camps. She will be well enough to return to school in the fall of 1910.

Case 70. Man aged 32 years. Examination showed both lungs affected. He was sent to Otisville, a place for early cases. From there he was sent to Riverside Hospital, a place for advanced cases. Both of these institutions belong to the Department of Health of the City of New York.

Case 71. Non-tubercular.

Case 72. Boy aged 18. Made one visit in September. Died in March, 1910.

Case 73. Non-tubercular.

Case 74. Man aged 30 years. Made one visit, October 13, 1909. Both lungs affected.

Case 75. Woman aged 48 years. Russian Hebrew. Aunt of Case 68. Has been a regular attendant at the clinic since October 13, 1909. She is married and has several children. Home conditions good.

Both lungs are affected and the patient has occasional hemorrhages. Bryonia is her regular remedy. When she has her hemorrhages she gets aconite, which seems to control them. She is gradually getting better.

Case 76. Boy aged 13 years. Has a tubercular laryngitis. Transferred to throat clinic. Home conditions bad.

Case 77. Man aged 33 years. Came to clinic October, 1909, to February, 1910. Slight lesion, right side. Spent his days at one of the day camp boats.

Nurse reports that this patient has a "lazy wife" and that the home conditions are bad.

Case 78. Non-tubercular.

Case 79. Non-tubercular.

Case 80. Boy aged 6 years. Left lung affected. Came to the clinic first on October 23, 1909, and has been regular in attendance ever since. The home conditions are good, but the patient does not get well.

Case 81. Non-tubercular.

Case 82. Non-tubercular.

Case 83. Non-tubercular.

Case 84. Boy aged 11 years. Slight lesion of one lung. The nurse got him a home in the country, where he now is.

Case 85. Non-tubercular.

Case 86. Non-tubercular.

Case 87. Woman aged 37 years. Patient made only two visits. The right side was slightly affected.

Case 88. Man aged 24 years. Both lungs badly affected. Advanced case. Patient dead.

Case 89. Non-tubercular.

Case 90. Woman aged 22 years. Patient made two or three visits during December, 1909. Both lungs badly affected; in advanced stages. Patient ordered home and to bed, where she died. The living conditions were good and the family was able to provide everything necessary.

Case 91. Man aged 29 years. Slight lesion left side of chest. Sent to Otisville.

Case 92. Man aged 28 years. Slight lesion left lung. When assured of the diagnosis this patient returned to his native place in Austria.

Case 93. Non-tubercular.

Case 94. Woman aged 21 years. This patient was an Italian woman, married. She had first attended the Bellevue clinic. From there she had been sent to Otisville for six months. On her return to New York in January she came to the Flower Hospital clinic. After a few visits she returned to Otisville. In June she reappeared at the clinic a few times. Now she is at Riverside. She has had an occasional hemorrhage, controlled by aconite. Her regular remedy while at the Flower has been bryonia. She is in good general condition, apparently. The lung condition does not clear up, however, and the outcome is doubtful.

Case 95. Non-tubercular.

Case 96. Woman aged 31 years. Slight lesion left side. Made two visits—January 17 and February 28, 1910—and was then transferred.

Case 97. Non-tubercular.

Case 98. Woman aged 29 years. Advanced case, both lungs. Moved out of the district in February and has since died.

Case 99. Woman aged 24 years. Advanced case, both lungs affected. This patient came to the clinic with her baby, *Case 100*, on January 31, 1910. She died in May.

Case 100. Baby aged 6 months. Child of the preceding. The baby had general tuberculosis and died in March.

Remarks.

The first thing that strikes one on looking over the above list is the number of non-tubercular cases presenting. This is largely accounted for by the thorough tuberculosis campaign that has been in vogue during the past few years. Many persons are sent by their relatives or friends for examination. The visiting nurse, or the Health Department nurse for the district, sends in suspicious cases for the same purpose.

The second point of interest is the large number that make but one or two visits. A few of these are lost altogether. The majority are transferred to their home clinics or to various institutions. The clinic serves a useful purpose here, because it gets the cases on record, and is then able to advise as to what had best be done for each individual.

The third point is the large percentage that are already dead. This shows that, notwithstanding the tuberculosis campaign, many cases of tuberculosis do not reach the clinic until far advanced in the disease.

The fourth point is the small percentage of cases that can be classified as ambulant cases, and the few of this small percentage that continue faithful and regular in their attendance.

The fifth and final point of interest is the few cases apparently cured. The time has been short, I know, in which to get much permanent benefit in the cases cited. It seems fair to assume that as time goes on and the few ambulant cases continue faithful in their attendance others of them will get well, thereby increasing the percentage of cures. One case cured in a hundred examined would justify the time and energy spent in the work.

GELSEMIUM.*

By H. P. Gillingham.

Without doubt, we all agree with Dr. Mills in characterizing *Gelsemium* as a Most Useful Remedy. The several classes of dis-

*In answer to Dr. W. S. Mills' paper.

orders in which the Doctor has found this remedy of service, as instanced in his paper, cannot be understood to indicate the *limit of range* of Gelsemium, for its sphere of influence stretches from the Dan of measles to the Beersheeba of posterior spinal sclerosis.

And through this vast extent, with its manifold phases of disease, runs the unceasing strand of this southern evergreen vine, which makes the medical picture of Gelsemium sempervirens always recognizable, always unmistakable.

It would be interesting to hear from the Doctor the specific symptoms presented by each of his several cases and upon which he prescribed. They—the symptoms—were undoubtedly there, and they were undoubtedly those of Gelsemium or there would have not been the response that the Doctor desired and obtained. But the "Text" which Dr. Mills asks me to find in his paper is right here: That unless the report of medical cures contains minutely the symptoms upon which the remedy was prescribed, it is too apt to encourage a sort of Routine Prescribing for—and on—*conditions* rather than *symptoms*.

For instance, I have frequently heard the complaint that Gelsemium had been exhibited in cases of Rigid Os, and had proved ineffectual; when upon inquiry it has developed that there were wanting the characteristic pains of Gelsemium in that condition—"Sharp pains, extending to the Back and Hips."

The Heart case referred to suggests an observation, namely, that Gelsemium is often an indispensable remedy in the course of organic-heart disease—valvular or otherwise. The condition may include action of varying kinds,—rapid or slow, strong or weak;—there may be pain of almost any character;—there may be Anguish, great or little;—*but the one cardiac symptom which makes Gelsemium the one remedy in the given case is the "Feeling that the heart would surely stop beating if the patient did not move about."* Given this symptom and Gelsemium is as useful and as reliable in its sphere in heart disease as Digitalis is in its sphere;—and, by the way, presents in this symptom the direct antithesis of Digitalis.

Finally, the Doctor seems to lay some emphasis on the fact that the chills—which he so properly describes as centering in the back—were *increased by motion*. I am unaware that this modality is found in the Gelsemium symptomatology. Perhaps I'm in error;—or perhaps, if it has been frequently observed, it should be added to our materia medica as a clinical symptom.

Feb. 10, 1910.

THE INTERNATIONAL AMERICAN CONGRESS OF MEDICINE AND HYGIENE

Buenos Aires, Argentine Republic,

May 25, 1910.

The International American Congress of Medicine and Hygiene of 1910 in commemoration of the first centenary of the May revolution of 1810, under the patronage of His Excellency, the President of the Argentine Republic, will be held May 25th in Buenos Aires, Argentine Republic.

In order to facilitate the contribution of papers and exhibits from the United States, there has been appointed by the President of the Congress, Dr. Eliseo Canton, and the Minister of the Argentine Republic at Washington, a committee of propaganda of which Dr. Charles H. Frazier (Philadelphia, Pa.) is Chairman and Dr. Alfred Reginald Allen (Philadelphia, Pa.) is Secretary.

The Congress has been divided into nine sections, each section being represented in the United States by its chairman in this Committee of Propaganda as follows:

Section 1—Biological and Fundamental Matters, Dr. W. H. Howell, Chairman, Baltimore, Md.

Section 2—Medicine and Its Clinics, Dr. George Dock, Chairman, New Orleans, La.

Section 3—Surgery and Its Clinics, Dr. John M. T. Finney, Chairman, Baltimore, Md.

Section 4—Public Hygiene, Dr. Alexander C. Abbott, Chairman, Philadelphia, Pa.

Section 5—Pharmacy and Chemistry, Dr. David L. Edsall, Chairman, Philadelphia, Pa.

Section 6—Sanitary Technology, Dr. W. P. Mason, Chairman, Troy, New York.

Section 7—Veterinary Police, Dr. Samuel H. Gilliland, Chairman, Marietta, Pa.

Section 8—Dental Pathology, Dr. George V. I. Brown, Chairman, Milwaukee, Wis.

Section 9—Exhibition of Hygiene, Dr. Alexander C. Abbott, Chairman, Philadelphia, Pa.

It will not be necessary for one contributing a paper or exhibit to the Congress to be present in person. Arrangements will be

made to have contributions suitably presented in the absence of the author.

The official languages of the Congress will be Spanish and English.

Members of the following professions are eligible to present papers or exhibits: Medicine, Pharmacy, Chemistry, Dentistry, Veterinary Medicine, Engineering and Architecture.

Papers may be sent direct to the Chairman of the particular section for which they are intended or to Dr. Alfred Reginald Allen, Secretary, 111 South 21st Street, Philadelphia, Pa.

DR. ERWIN SCHENK.

Dr. Erwin Schenk is a prominent Des Moines physician who has been appointed to the chair of general medical practice and theory at the Iowa University, which formerly was occupied by Dr. J. W. Dickinson, Sr., of this city. He was selected from a field of applicants which included many of the most prominent physicians in Iowa. His duties, which will require his presence at the university one day of each week, consist of diagnosis and treatment of diseases.

Erwin Schenk, M. D., has been graduated from the Iowa State Teachers' College, the science course at the Iowa University and the medical course at the New York Medical College. He has spent two years at the Berlin University, studying under Professors Virchow, Bon Bergman Lassar and Mendel. Before beginning practice in Des Moines he was a resident of Waterloo, Ia.

EDITORIAL

WALTER SANDS MILLS, EDITOR.

The October issue of the *CHIRONIAN* will be directed by Dr. Walter Sands Mills, who has been chosen to fill the post of editor.

Dr. Mills comes to the *CHIRONIAN* with some years of experience as associate editor of the *North American Journal of Homœopathy* back of him.

With his past record we shall expect great things from him, and we who know him best know we shall not be disappointed.

ANNOUNCEMENT OF CHANGES AND IMPROVEMENTS AT THE NEW YORK HOMŒOPATHIC MEDICAL COLLEGE.

Change and growth are two words which may indicate opposite conditions, or they may be used synonymously. In this connection we wish to use them in the latter sense, and we are confident the present viewpoint of the medical college critic gives us this privilege.

The Carnegie Foundation for the Advancement of Teaching has shouldered the self-imposed burden of investigating the conditions of medical instruction and academic administration in North America. The voluminous report is in the hands of the public, and all who read must be impressed with the alleged fact that medical standards are humiliatingly low.

The preachments and conclusions of the author are necessarily his very own and need not concern us. Certainly his words regarding "sectarianism" are in themselves narrowly sectarian. However, it is the American privilege to form and hold opinions, and we have no quarrel with Dr. Flexner simply because he does not share our ideas. We have, on the other hand, to give him our thanks for a searching and painstaking report on the physical and moral conditions of the individual medical colleges of the Continent.

From the homœopathic standpoint it might seem, at first, that our own institutions are particularly bad. However, a more careful reading indicates that the percentage of good to bad colleges is, if anything, higher than that of the dominant school. Our own college, the New York Homœopathic, comes out of the fray with flying colors. We do not mean to imply that Dr. Flexner left us

unscathed, but in the light of improvements now under way, it seems to us that by the Carnegie standard our institution, about as closely as any in the country, approximates the ideal.

At the time of the official inspection Dr. Flexner told the writer that our college should be the envy of every other New York institution because we own and control our own hospital. President Schurman, of Cornell, in a recent address, condemned the entire group of New York City medical colleges, saying that not one possessed this essential privilege; indeed, to quote his language, "No first class medical school in the United States possesses a hospital of its own." He overlooked or disregarded the fact that our corporation, with its long and awkward name, is in the enviable position of holding in one business and operative control, the New York Homœopathic Medical College and Flower Hospital. The importance of this condition is best told in Dr. Flexner's own language. After discussing clinical teaching as ordinarily given in local hospitals, public or private, with no direct connection with the medical school, he says:

"A long list of such supplementary opportunities scattered through the town is no substitute for the fundamental teaching and working hospital, on the existence of which even a fairly satisfactory use of additional and imperfectly controlled clinical material depends. Indeed, without such a teaching hospital, the school cannot even organize a clinical faculty in any proper sense of the term. The control of the hospital by the medical school puts another face on its relations to its clinical faculty. What would one think of an institution that, requiring a professor of physics, began by seeking some one who had his own laboratory or had got leave to work a while daily in a laboratory belonging to some one else? That is the position of the medical school that, in order to gain even limited use of a hospital ward, has to cajole a staff physician with a professorial title! When the hospital belongs to the medical school, appointments are made on the basis of fitness, eminence, skill. A man is promoted if he deserves it, if a better man is available elsewhere, he is imported. Opportunities are his in virtue of the university's choice; it is absurd to reverse the order. The men thus freely selected will be professors in the ordinary acceptation of the term; they hold chairs in an institution resting on a collegiate basis—a graduate institution, in other words. They will be simultaneously teachers and investigators. Non-progressive clinical teaching involves a contradiction in terms. The very cases which are exhibited to

beginners have their unique features. New problems thus spring up. Every accepted line of treatment leaves something to be desired. Who is to improve matters, if not your university professor, with the hospital in which he controls conditions, with a dozen laboratories at his service for such aid as he summons, with a staff who will be eyes and ears and hands for him in his absence? These conditions exist in Germany, and clinical science has there thriven; they are lacking here, and clinical medicine droops in consequence."

It is doubtless true that in times past and even as late as the official visit, we had not awakened to the fullest appreciation of our clinical possibilities. However, from the first of last February, there has been in effect a schedule of student activity, purposely planned to give the undergraduates the benefit of bedside instruction, case taking, physical and laboratory examinations, and actual prescribing. One of the improvements for the next college year is the outgrowth of this idea. Daily work of this sort is to be required of each student. He will be in actual charge of at least one person at a time of the patients in the hospital. Without proper supervision this would be a time consuming but largely useless procedure. To give direction and inspection to such an undertaking requires aptitude and preparation. It requires a director who is an able diagnostician, an observant clinician, who possesses laboratory knowledge covering the whole realm of the modern methods, who knows the values of the instruments of precision, and who has knowledge of and faith in remedies, as well as discriminating information regarding adjuvant treatment.

It might not be difficult in a great medical center like New York to find such men, but it is hard indeed to find one who will sacrifice the time necessary to devote hours every day in the year to this important labor. To this end the authorities have relieved Dr. Harrison G. Sloot of his editorial duties, and, believing him to be exceptionally endowed for the place, have made him director of the clinical laboratory, with direct oversight of the student work in the hospital. Readers of the *CHIRONIAN* will miss his familiar hand, but the cause of medical education is to be congratulated that Dr. Sloot has accepted the new appointment. The doctor will discontinue his former college work, but will remain in charge of his dispensary clinic.

The laboratory heretofore used by the department of bacteriology is being fitted up as a clinical laboratory, and here the student will make such laboratory tests as are essential to diagnosis and

treatment. Each senior will be assigned a table for his daily use through the year and will be given such reagents and apparatus as are necessary. The director will be in daily attendance for the required time of the student, and the laboratory will be constantly open for the use of those who take special interest in this work.

This laboratory, together with the work in the wards, will correlate and apply in a practical way, the work of the departments of pathology, bacteriology, physiology and physiological chemistry. The course, it seems to us, must give every graduate an intimate and most unusual knowledge of medical methods. It will make him familiar with the etiquette of the sick room, with case taking, with the natural history of disease, with symptom taking, and with actual methods of treatment.

The alumni will be particularly interested in the use made of their generous gift to the college. This has been amplified by the trustees and other friends, and the new laboratories will be ready for the students soon after college opens. This writer feels the need of a restraining hand when he attempts to describe this addition to our equipment. The truth is, however, that the new laboratories of bacteriology and physiology will be the most modern and best equipped of their kind in America. There are many larger, there are a few almost as new, but all who have seen the plans agree that no other institution can approach this in the excellence and perfection of its new laboratories. The architect, Mr. Raymond F. Almira, has a splendid reputation for scientific construction, but he approached this problem in an inspired mood.

The bacteriological laboratory, including the class room, the medical room, the preparation room, and research quarters, takes an entire floor of the west wing, occupying the same floor space as Alumni Hall. In the class room a section of forty men can work at one time, each having his own desk and equipment.

The physiological laboratory is on the floor below, immediately above the library, with floor space about one-third greater than the library. It is equipped with individual tables, shafting, dissecting tables, paraffine room, etc.

The new junior lecture room is so arranged that the students are brought close to the lecturer, and demonstration in anatomy and physiology may be readily observed. A fine projectoscope, for opaque as well as transparent objects, is installed. Lighting and ventilation of all these rooms have been given careful attention, and the health and comfort of all concerned have been kept in mind.

Last year we added the five-story building to the west of the dispensary and fitted it up as a nurses' home. This was done without addition to our heating plant, and, as a consequence, there were days last winter when it was exceptionally difficult to keep all our buildings comfortably warm. To avoid a repetition of this experience, two additional one hundred and sixty horse-power boilers have been installed. This will care for the present plant and for extensions for some years to come.

In the college building the trustees have contracted for about twenty-five thousand dollars' worth of improvements. Extensions here are like municipal improvements, not only are they expensive to install, but they add materially to the annual budget for maintenance. New laboratories involve new directors, and, under the conditions of medical education as prescribed by the Carnegie Foundation, these must be full-time teachers. In the budget for 1910-1911 the authorities have provided for full-time or salaried directors for the laboratories of pathology, bacteriology, physiology, chemistry, anatomy, and clinical instruction.

Dr. John W. Dowling, the efficient secretary of the faculty, has found that the growing demands of his private practice make it impossible to attend to the details of the registrarship. Loath to part with this valuable official, the trustees have relieved Dr. Dowling of that part of his duties having to do with the student relationship, but are glad to announce that he will continue to serve as secretary of the faculty. A new office has been created, or rather an old one has been resurrected, and hereafter the registrar will supervise the student records.

Of the six laboratory directors we wish to speak particularly of two. The first of them is the new professor of bacteriology. The writer speaks with special affection of this appointee, Dr. Joseph H. Ball, because he is a child of the same preceptor, dear Dr. Edgar F. Chase, the prince of preceptors, of Ann Arbor, Michigan. Dr. Ball, repeatedly elected registrar of the American Institute of Homœopathy, by his activity in that office and in the organization, has a wide and favorable acquaintance with the homœopathic profession. Years ago he was assistant to Dean Copeland at the University of Michigan, and one year of that time, owing to the ill health of Dr. Copeland, was acting registrar. After leaving the university, Dr. Ball was appointed by the Governor a member of the Michigan State Board of Registration in Medicine, a position he resigns to come to New York. This board has the same jurisdiction over pre-

liminary and medical education as have the Board of Regents and the Department of Education in this State. Dr. Ball's long time service in this capacity and especially his chairmanship of the important Committee on Curriculum and Standards have made him a recognized authority on medical education and the laws of medical practice. Dr. Ball has been appointed registrar. His ripe experience and perfect familiarity with medical registration will be most helpful in this day of complex requirement. One must needs be the equal of the proverbial "Philadelphia lawyer" to solve the mazes of the medical law as it winds in and out of the different States and countries. We know of no one who is more the master of this subject than is Dr. Ball. No one can be closer to the heart of the student body than is Dr. Dowling, but Dr. Ball's familiarity with students, born of long association with them, makes him a worthy successor to the registrarship. In his office of secretary, Dr. Dowling will lend a helping hand until the strangeness of new names and faces is a thing of the past.

During his life at the University of Michigan, as student and instructor. Dr. Ball, was devoted to the subject of bacteriology. This has been his fad and hobby since. With Dr. Lloyd ophthalmology has been his vocation, and as anatomy has been the avocation of the one, bacteriology has been the avocation of the other. Dr. Ball has kept abreast of the progress of this relatively new science, and has been spending the past several months in the laboratories of the masters of the subject. He will bring the most recent ideas of bacteriology in general, as well as of the vaccines, sera, and opsonins, and all the modern theories of infection and immunity. Dr. Ball is a splendid teacher, forceful and insistent, and withal has a perennial enthusiasm which is the joy of his friends. The laboratory of bacteriology will be heard from under the generalship of this director.

We regret to announce that Dr. Albert E. Hinsdale has resigned the professorship of chemistry and has returned to Ann Arbor. Prof. Hinsdale, the able son of a brilliant father, made a lasting record by his work with us, and it is with genuine sorrow that we chronicle his departure. He prefers the activities of practice to the exactions of laboratory life. We bespeak for him happiness and success in his new-old field.

The new director of the chemical laboratory and professor of chemistry is Farel E. Jouard, A. M., Ph. D. Dr. Jouard is a dis-

tinguished scholar, several times a graduate of Columbia, and is already looked upon as a chemist of note. He has been an instructor in Columbia University, teaching there a subject of present day interest to every Homœopathist, electrochemistry. He brings to us a knowledge of physical chemistry which must go far towards emphasizing the scientific foundation of our beliefs. Dr. Jouard has been a profound student of medical and physiological chemistry, as well as the more fundamental branches of the subject. He will devote his spare hours to research work in the chemistry of the proteids and to other subjects of interest to the medical and scientific world. Prof. Jouard will spend all his time at the college.

In speaking of these men it seems almost a pity to overlook the old ones. But Prof. Charles McDowell, in physiology; Prof. Louis Heitzman, in pathology; Prof. Ralph I. Lloyd, in anatomy, and Prof. Edwin B. Munson, in histology, have already won their spurs. and by devoted service to the institution taken possession of the hearts of students, alumni, and friends of the institution. In every scientific department the student is assured of equipment, apparatus and the most advanced teaching. No other institution on the face of the earth is better equipped for modern work than is this. The father may send his son, or the preceptor his student, in full confidence that no better place can be found. Measured by any standard, homœopathic, allopathic or eclectic, there is not better medical school anywhere.

On the practical side, the purely medical and surgical subjects are all taught. Flower Hospital with its immense ambulance district gives unrivalled opportunities for the study of emergency cases, both medical and surgical. In the dispensary last year over forty-one thousand visits were made. The out-door department, through its director and student attendants, made more than 7,000 calls. What other institution can equal this record?

If one were to pass judgment upon the conclusions of the Carnegie Foundation, he must say that Dr. Flexner has overshot the real purpose of the medical college. He has in mind the training of men for medical research and not for the emergencies of actual practice. One might be the ablest architect in all the world and yet not be able to follow a straight-edge with a saw or to drive a nail. Admitting the need of scientific training and giving the laboratory its proper place, there yet remains a more important thing—the *art* of medical practice. Without this all the rest is as nothing. So, in our curriculum, we make much of practical things

and try to familiarize the student with the actual conditions confronting the graduate in his daily work.

At the close of college each department made a report for the past year. In this connection, a quotation from Prof. Danforth will give a very good idea of the privileges of the student in this particular department, obstetrics:

"The senior class during the year just closed enjoyed exceptional opportunities for practical instruction. Our obstetrical service among the poor people on the East Side gives us from twenty to twenty-five cases per month. This with the special courses taken in affiliated institutions, the privileges of which the students avail themselves of during the summer months, enabled our senior class just graduated to care for personally an aggregate number of 350 cases, or an average of about 20 cases for each man. This is a remarkable showing for young men who are about to take up the practice of medicine. We have exceeded the average number of confinement cases required by first-class colleges for each student prior to graduation. The number required by other schools is six cases for each man. Not one of our men but had more than this, and one had officiated at 60!

"Obstetrics is the most important branch of medical practice. Each confinement case represents two patients, which at once arithmetically proves the statement. More than 6,000 women die annually in the United States during confinement. Countless numbers are made invalids for life from injuries received or disease acquired while performing the functions of reproduction. The practice of obstetrics requires unusual knowledge, the highest judgment and great skill. Obstetric complications are the most formidable which the practitioner has to meet. It is our earnest endeavor to educate students thoroughly in this important branch of medical learning."

After twenty years of active labor in the institutions of New York, Dr. George W. Roberts feels that he is entitled to a well merited rest. No cleverer surgeon ever used a knife, and no better medical teaching was ever given than by Prof. Roberts. He will be missed by students and profession. His place in the Department of Gynecology will be ably cared for by Dr. Walter Gray Crump. Dr. Crump, by reason of his long-time association with the College, is well and favorably known to the alumni and profession.

In Homœopathy we have an able corps of instructors. The therapeutic clinic, conducted by Dr. Rabe and his co-workers, is one

of the most inspiring features of the institution. This department will miss the genial and popular Dr. J. Wilford Allen, but it will not lose in efficiency because Dr. Arkell R. McMichael has been added as Professor of Materia Medica and Therapeutics. Dr. McMichael, as author, teacher in the Woman's College, and successful practitioner, is too well known to need words of praise or commendation. Dr. Spencer Carleton, too, will appear in the Department of Materia Medica. As writer and speaker his enthusiasm is infectious and his arguments most convincing.

The alumni and friends of the institution have the opportunity now to show their loyalty. There can be no excuse of lack of equipment or facilities. The student who passes the doors of this college must do so deliberately. We really feel that we deserve a large class this fall, and we expect one. We owe it to the trustees to do our part to that end. C.

SOCIETIES.

New Jersey State Homœopathic Medical Society.

Annual Announcement, 1910-1911.

Newark, N. J., August, 1910.

The coming meeting of the society bids fair to be one of great interest. Montclair has been selected as the place of meeting, with headquarters at the Montclair, Crestmont Road.

Let us stand by our colors! It is very important that every member be present at this meeting, and we trust that you will do your part by being present and come prepared to give us the best of your experience and counsel. The study of homœopathy is the object of the society, the conservation of homœopathic interests its watch-word.

Have you been absent from meetings, you should have attended? If so, when you repent, you will be forgiven.

The society will hold its business session on Wednesday at 3 P. M., in the Montclair.

If you know of any homœopathic physicians living in the State who do not belong to the State Society, present their names for membership at the coming meeting.

Chairmen of Bureaus are requested to notify the secretary at an early date the subject of the papers they propose to present. Please have papers written plainly; if possible, typewritten.

The names of those appointed to the various bureaus follow.

While the omission of a name does not deny any member the privilege of contributing, it does place an obligation upon each one chosen to do his share towards making a success of this annual meeting.

Let us then be up and doing,
His law deserves its fame.
Throw away the rag you're chewing,
Its truth is e'er the same.

CARL HERMAN WINTSCH, M. D., *President*.

Committee of Arrangements.—Chas. H. Church, M. D., W. S. Baker, M. D., Wm. F. Beggs, M. D., Florence Edgar Voorhees, M. D., Sarah D. Smalley, M. D., Carl H. Wintsch, M. D., Phillip C. Kirchbaum, M. D., Wm. H. Cooke, M. D.

Fifty-eighth annual session, the Montclair, Montclair, N. J., May 17th, 18th and 19th, 1911.

Officers, 1910-1911.

President.—Carl Herman Wintsch, M. D., 188 Fairmount Ave., Newark.

First Vice-President.—A. W. Atkinson, M. D., Trenton.

Second Vice President.—Frank Parker Ekins, M. D., Paterson.

Third Vice-President.—Walter H. Phillips, M. D., Cape May.

Recording Secretary.—Alfred Drury, M. D., 160 Broadway, Paterson.

Corresponding Secretary.—Charles F. Hadley, M. D., 3320 Federal Street, Camden.

Treasurer.—Llewellyn E. Hetrick, M. D., 53 Cookman Ave., Asbury Park.

Censors.—E. Roberts Richie, M. D., Moorestown; B. H. Garrison, M. D., Red Bank; A. Katherine Klein, M. D., Jersey City; Charles F. Adams, M. D., Hackensack; Lee E. Griscon, M. D., Camden.

Necrologist.—H. F. Datesman, M. D., Passaic.

Committees.

The Executive Committee.—The President, the Vice-President, the Recording Secretary, the Corresponding Secretary, the Treasurer.

Publication Committee.—The Executive Committee.

Committee on Ethics.—The Fellows, the Executive Committee.

Auditing.—E. M. Howard, M. D., Camden; Edwin T. Davis, M. D., Bound Brook; Frank S. Carpenter, M. D., Newark.

Legislature.—V. A. H. Cornell, M. D., Trenton; Chas. B. Holmes, M. D., Rahway; J. H. Bryan, M. D., Asbury Park; A. S. Fell, M. D., Trenton; H. H. Grace, M. D., Camden.

Registration and Statistics.—C. F. Hadley, M. D., Corresponding Secretary, Camden; Alfred Drury, M. D., Recording Secretary, Paterson; H. R. Faringer, M. D., Mount Holly; Chas. H. Church, M. D., Newark; George D. Fay, M. D., Atlantic Highlands.

Bureaus.

Materia Medica and Drug Proving.—Phillip E. Krichbaum, M. D., Montclair; Edward Rushmore, M. D., Plainfield; A. Katherine Klein, M. D., Jersey City; Wallace McGeorge, M. D., Camden; Frank P. McKinstry, M. D., Washington.

Clinical Medicine and Pathology.—Arthur F. Thompson, M. D., East Orange; J. G. Streets, M. D., Bridgeton; E. W. Hamilton, M. D., Oakland; Joseph C. Bitler, M. D., Hammonton; Elwood Easton, M. D., Newark.

Surgery and Gynæcology.—E. M. Howard, M. D., Camden; Chas. A. Church, M. D., Passaic; B. H. Garrison, M. D., Red Bank; E. Roberts Richie, M. D., Moorestown; B. H. B. Sleight, M. D., Newark.

Obstetrics.—Lee E. Griscom, M. D., Camden; Florence V. Voorhees, M. D., Newark; H. C. Garrison, M. D., Camden; Francis McConaughy, M. D., Somerville; Ella P. Upham, M. D., Asbury Park.

Physical Therapeutics.—Chas. F. Adams, M. D., Hackensack; Jos. H. Bryan, M. D., Asbury Park; J. H. Cooley, M. D., Plainfield; C. H. Church, M. D., Newark; Maurice D. Youngman, M. D., Atlantic City.

Pedology.—B. W. Giveans, M. D., East Orange; W. H. Phillips, M. D., Cape May; F. P. Ekins, M. D., Paterson; J. H. Beekman, M. D., Sayreville; T. E. Parker, M. D., Woodbury.

Sanitary Science and Public Health.—E. S. Sheldon, M. D., Collierswood; G. Herbert Richards, M. D., Orange; C. C. Allen, M. D., Absecon; J. T. Beckwith, M. D., Atlantic City; Chas. S. Mills, M. D., Riverton.

Ophthalmology, Otology and Laryngology.—Wm. F. Beggs, M. D., Newark; T. H. Lemmerz, M. D., Jersey City; Clinton C. Straughn, M. D., Matawan; C. D. Saul, M. D., Camden; George G. Jackson, M. D., Newark.

Homœopathy.—Harriet K. Burnett, M. D., East Orange; Sarah

D. Smalley, M. D., Newark; R. F. Rabe, M. D., New York, N. Y.; John Younglove, M. D., Elizabeth; C. H. Hubbard, M. D., Chester, Pa.

Delegates.

Interstate Committee of A. I. H.—A. W. Baily, M. D., Atlantic City (1913); Carl H. Wintsch, M. D., Newark (1915).

New York State Hom. Med. Society.—B. H. B. Sleght, M. D., Newark; R. F. Rabe, M. D., New York, N. Y.

Pennsylvania State Hom. Medical Society.—C. H. Hubbard, M. D., Chester, Pa.; L. Dow Balliet, M. D., Atlantic City.

West Jersey Hom. Med. Society.—F. W. Cornwell, M. D., Plainfield; T. S. Davis, M. D., Plainfield.

Essex County Hom. Med. Society.—James F. Ackerman, M. D., Asbury Park; L. A. Opdyke, M. D., Jersey City.

Atlantic City Hom. Med. Society.—Ralph Iszard, M. D., Haddonfield; F. E. Williams, M. D., Haddonfield.

Monmouth Co. Hom. Med. Society.—L. E. Griscom, M. D., Camden; C. F. Hadley, M. D., Camden.

Mercer Co. Hom. Med. Society.—W. W. Knowlton, M. D., Camden; E. M. Howard, M. D., Camden.

N. J. State Sanitary Association.—Armin Ubelacker, M. D., Morristown; Laban Dennis, M. D., East Orange.

The Homœopathic Medical Society of the State of New York.

The Homœopathic Medical Society of the State of New York will hold its semi-annual meeting at Rochester, N. Y., September 13th and 14th, 1910. Hotel headquarters, Powers Hotel. Sessions and exhibits, Powers Hotel. The local committee has arranged a dinner and theatre party for the social entertainment of all, including the ladies. The latter will also be entertained socially by the Ladies' Committee. A good time for all is promised. The scientific programme is especially good and includes addresses by the following invited guests: William A. Howe, M. D., Deputy Commissioner of Health of N. Y. State; George W. Mackenzie, M. D., Philadelphia, Pa.; Adolph E. Ibershoff, M. D., Cleveland, Ohio. Nominations for officers for 1911-1912. Programme will be mailed to you next week. Bert B. Clark, M. D., Secretary.

ALUMNI NOTES.

Dr. R. L. Eltinge, '01, of Dorchester, Wise County, Va., was in town with his wife recently. "Elt" is looking splendidly and is enthusiastic over his Virginia home and practice.

Dr. Carl Herman Wintsch, '95, desires to announce that he will resume practice on Monday, August 15th, 1910. Hours as before. Special attention to diseases of the rectum. 188 Fairmount Ave., Newark, N. J. Telephone 4776-W Market. Office Hours: 8-9 A. M., 1-3 P. M., 6-8 P. M. Sundays and Thursdays until 10 A. M. only, and by appointment.

Edwin C. Buell, N. Y. H. M. C. and H., '76, a member of the California State Board of Medical Examiners from 1901-1907, of Los Angeles, Cal., died in Genoa, Italy, while touring Europe, July 20, from appendicitis, aged 57.

Dr. H. Krogstad, class of '89, has been spending his vacation touring the New England States and Canada.

Dr. Gregg Custis, Sr., class of '78, has spent the summer with his family at his camp near Clayton, New York.

Dr. Gregg Custis, Jr., spent July at camp and has since had charge of his father's practice.

Dr. Riggs, class of '82, spent the summer at Mountain Lake Park, Md.

Dr. Hawxhurst, class of '91, spent the summer at Madison, Conn., with his family.

Dr. Wm. R. King, associate alumnus, is spending his vacation in the Thousand Islands.

Dr. Swormsted, associate alumnus, is at Shawnee, Pa., for the summer.

The new Homœopathic Medical Examining Board of the District of Columbia consists of Drs. J. B. G. Custis, president; G. C. Birdsall, secretary; R. Kingsman, J. S. Stearns, F. A. Swartwout.

Any one desiring interneship in the National Homœopathic Hospital please communicate with Dr. G. C. Birdsall, secretary of medical staff, as a vacancy is now open.

BROOKLYN NOTES.

Dr. Wm. H. Price, Pulte '03, is the proud father of a fine boy.

Drs. Herbert C. Allen, '96, and G. Rodney Fishe, '95, are spending the summer at Lake Placid Club, N. Y.

Dr. Reuben T. Johnston, Boston Univ. '03, has been elected physician to the Brooklyn Nursery and Infants' Hospital.

Dr. O. DuBois Ingalls, '03, has been transferred from the obstetrical service of Cumberland Street Hospital to assistant surgeon.

Dr. R. T. Walmsley, '94, has been appointed visiting surgeon to Cumberland Street.

Dr. Clark Burnham is spending the summer at Manchester, Vt.

Drs. S. W. Pallister, '98; C. S. Van Schoonhoven, '78, and W. H. Freeman, Chicago '00, have recently become converts to the automobile.

This is all the August news "that's fit to print" for Brooklyn.

BOOK NOTICE.

MENTAL DISEASES AND THEIR HOMŒOPATHIC TREATMENT. By William Morris Butler, A. M., M. D., formerly First Assistant Physician to the Middletown State Homœopathic Hospital for the Insane; Professor of Mental Diseases, N. Y. Homœopathic Medical College and Flower Hospital; Consulting Alienist, Middletown State Homœopathic Hospital for the Insane; Neurologist, Cumberland Street Hospital; member American Institute of Homœopathy; Ex-President Homœopathic Medical Society of the State of N. Y. Boericke & Runyon, New York, publishers.

In this work the opening pages are devoted to the legal phase of the subject. Insanity is defined and the proper precedure in committing the mentally sick to proper places discussed. Then follows a modern classification of mental diseases, in which the author follows the work of Kraepelin.

General etiology and symptomatology forms a good introduction to the discussion of the various types of insanity with which the book deals.

The special homœopathic therapeutics as related to mental diseases is concise but full enough to give a clear picture of drug pathogenesis.

For easy reference marginal notes have been introduced, which save much time and labor in looking up special symptoms and conditions.

The few illustrations in the books have been excellently done.

Price, \$3.50.